TEXAS DEPARTMENT OF LICENSING AND REGULATION

www.tdlr.texas.gov

COMPLAINT FORM

Mail To:
TEXAS DEPARTMENT OF LICENSING AND REGULATION
ENFORCEMENT DIVISION
P.O. BOX 12157 • AUSTIN, TEXAS 78711
(800) 803-9202 • (512) 539-5600
FAX 512-539-5698

Date Received:
(For Department Use Only)

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TDLR ENFORCEMENT

AUG - 7 2017

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Notice

Under the Texas Public Information Act, the complainant's identity is not confidential. In the event your complaint is opened for investigation, enforcement procedures require a copy of the complaint and all associated documentation be forwarded to the Respondent including your name and contact information.

A. You, as the complaining party: *(If you wish to file your complaint anonymously to ensure your identity is not revealed, you must leave this section blank. If you file your complaint anonymously you will not receive case status updates.)*

Name: [redacted]

Address: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]

Work Phone: Home Phone: [redacted] Fax:

E-Mail: [redacted]

Contact from the Department will be via e-mail if you provide an e-mail address

B. Would you be willing to testify if this case goes to a hearing? Yes ☒ No ☐

C. The person, firm, building or facility you are complaining about (Respondent):

Name: Roswitha Dowell

Company or Facility Name: Austin Area Birthing Center

Physical Address: 4100 Rural Road Bldg #2 Suite #101

City: Austin State: TX Zip: 78759

Mailing Address (if different than above):

City: State: Zip:

Telephone numbers: Office - Fax-

E-mail:

License or Registration Number: 05013

D. Explanation: Describe your complaint in detail. Include dates, names, locations, type of service provided by respondent and events leading to you filing this complaint. If the space provided below is not adequate, you may attach additional pages. **Please include** with your complaint, any documentation regarding your complaint.

If you are filing your complaint anonymously it is important that you include any associated documentation (making sure you have removed your name from all documentation). If the information provided with your complaint does not contain enough information for the Department to believe a violation may have occurred, your complaint may not be opened for investigation.

Please see attachment

SIGNATURE BLOCK

[redacted] mplaining party

Aug. 4, 2017
Date

My name is [redacted]. I am 41 years old, and became pregnant through an IVF procedure in August 2016 after three years of IVF procedures, including 6 embryo transfer procedures. On May 13, 2017, in my 41st week of pregnancy, I delivered my stillborn daughter, Elliott Jane Glisson, at St David's North in Austin with the attending obstetrician, Dr. Brian Monks. Prior to delivery, I had been under the care of the midwives at the Austin Area Birthing Center. Despite numerous indications that medical intervention was necessary, they did not refer me to an obstetrician or a hospital for the appropriate care before my baby died.

Following delivery, Dr. Monks told me I should not have been allowed to carry my pregnancy past 39 weeks due to my IVF pregnancy and my advanced maternal age (I was 1 week from my 41st birthday when I delivered my stillborn daughter). He said mine was a high-risk pregnancy and that the Austin Area Birthing Center should not have accepted me for care with my pregnancy due to these factors. Further, he said he found no evidence that any medical doctor had been consulted regarding my pregnancy, ultrasounds and early labor, as is standard practice. He stated that he would be initiating a peer review of my case.

I believe that the Austin Area Birthing Center should be sanctioned so that what happened to me does not happen to other women with circumstances like mine. Their contract with me, and I assume other women like me, states that they do not accept high-risk patients. Further, their contract states that they routinely consult with an obstetrician during the course of the pregnancy. Their contract requires that a patient in early labor for 48 hours be transferred to the care of an obstetrician. Not only did they fail to meet the terms of their contract regarding my care, but also I believe they were grossly negligent in the care of my baby and me.

Attached is my recollection of the events and circumstances of my case.

What happened to my baby, Elliott Jane Glisson, has been devastating to me and should not be allowed to happen again to anyone. I hope to hear from you regarding your attention to this case. Please feel free to contact me by phone at [redacted], by email at [redacted] or at my home address [redacted].

Sincerely,

[redacted]

I was accepted as a patient of Austin Birthing Center in October of 2016 when I was 12 weeks pregnant.

I had an anatomy ultrasound on 12/22/16 at which time I was told that my daughter was approximately 50th percentile. I was 21 weeks pregnant at the time.

My next ultrasound was at week 34 on 3/24/17 to check the baby's position to ensure that her head was down in preparation for birth, which it was. Later on that morning during my physical exam, the midwife, Rachel Slaughter, mentioned when she manually measured fundal height (using a tape measure on the exterior of my stomach) that the baby was measuring the same as she did two weeks prior (31cm on 3/10 and again on 3/24). She said that she wasn't concerned about it but that they would need to see growth at my next appointment in 2 weeks.

At my 36 week appointment on 4/7/17, the midwife (Merlene Grover) measured my fundal height at 35cm (again, using a tape measure on the exterior of my stomach). I said that I had been concerned about her growth since it my previous two fundal height measurements were the same. She said that the baby may have been turned or positioned in a way to have her measure small previously. Kim Sennet was also in attendance during this exam.

At my 38 week appointment on 4/21/17, Rachel Slaughter examined me and said that it felt as though my fluid was low and suggested we might want to follow up on it. I asked for an ultrasound--it was Friday and I was aware that they have an ultrasound technician in the office on Fridays. Rachel said that we probably couldn't get me in for an ultrasound since they are booked up so I would probably need to wait until Monday. I said that I wasn't willing to wait until Monday and if they couldn't get me in I would find someone else who could see me that day. After she continued examining several other patients, she returned and said that they would fit me in for an ultrasound. During the scan, the technician reported that the baby was quite small-in the fifteenth percentile- but the midwife and the technician said that it wasn't anything to be concerned about. She also said that the amniotic fluid was within the normal range.

At my 39 week appointment on 4/28/17, I was examined by Anne LeCirque. She did not perform or recommend an ultrasound to follow up on my amniotic fluid or my baby's small size.

At my 40 week appointment, on May 5—my due date, fundal height was measured manually again (by Kim Sennet) and deemed to be normal (I did not record that measurement). She also said that my fluid felt fine (based on touching my abdomen). No ultrasound was performed.

My labor began two days later (2 days past my due date) with contractions on Sunday night May 7, approximately 30 seconds long and consistently about an hour apart.

They slowed on Monday during the day, but did not stop. I inserted capsule of Evening Primrose oil vaginally (per Rachel's suggestion at my 5/5 appointment) at bedtime. Contractions continued and intensified throughout Monday night, increasing in duration to about 1 minute long, and remaining at about hourly intervals throughout the night.

On the morning of Tuesday May 9 the contractions slowed again. I had an appointment for acupuncture at 11:30 (again, per the midwives' suggestion). Contractions picked up in intensity that afternoon around 3:00 and I began timing each one. They increased substantially to the point that I asked my doula to come to the house as I needed assistance managing the pain. They ranged from 20 minute intervals to 2 minute intervals. We called the birthing center around 2am to find out if this was concerning and if I should come in. My mom explained to the midwife that I had been in early labor with contractions since Sunday night. My mom told her that my contractions had increased in intensity that afternoon and had increased in intervals to as close together as 5 minuted and 2 minutes apart over the past several hours, but that there were some contractions that were 10 or 15 minutes apart. The midwife on call said that I wasn't in active labor. She asked to speak to me and I reiterated this information in between contractions. She said that it didn't sound like I was in active labor. She frankly sounded annoyed with me and said that if I wanted to come in I could but said that if they confirmed that I wasn't in active labor, which it didn't sound like I was, that they would send me home. I said that I didn't want to have to go through the intense contractions in the car only to be sent home so if that's what was going to happen and if that I would wait until they are more regular. I continued to labor at home and contractions slowed but remained intense.

By the morning (Wednesday May 10), I was still having intense contractions. I called AABC and requested an appointment to have my cervix and the baby checked. They agreed to see me at 11:30. Kim Sennet examined my cervix and indicated that I was dilated to 1 cm and 80 percent effaced, and the baby's heart rate was normal at 140BPM per the handheld fetal doppler. I was still concerned since I had been in labor since Sunday and I asked if they should do a non-stress test at this point and she said no, the baby is fine. I told her that I had been in labor since Sunday night (3 days), but she said that was normal. She recommended another acupuncture treatment and evening primrose oil to further soften my cervix and suggested that I take a Tylenol PM to help me sleep at night. We left. I took a Tylenol PM early per her suggestion (possibly around 6pm) but I was awakened about every hour by contractions. I passed my mucus plug around 9:30pm. Contractions remained intense but were still between 10-40 minutes apart.

On Thursday labor slowed even more, but the baby was very active. Her movements were visible from the exterior of my abdomen.

On Friday morning I didn't feel her. I had an appointment for a non-stress test at 11:00 at Austin Birthing Center so I tried to stay calm, ate breakfast, then some juice and candy—hoping to wake her up--but still didn't feel anything.

When my mother and I arrived at the birthing center I signed in and told the front desk attendant that I was stressed out because I hadn't felt the baby move today. We waited for about 10 minutes and were escorted to a birthing room. I laid down on a bed on my side. The technician couldn't find a heartbeat with the non-stress test equipment. They brought in a midwife, Roswitha Dowell, who used a fetal Doppler. She just shook her head as she held it to my stomach. She didn't explain what was happening-I thought there was something wrong with the Doppler. Someone (there was a technician and possibly a midwife assistant in the room as well) then suggested that we get an ultrasound. It was Friday so the ultrasound technician was in the office (they do not always have ultrasound equipment). They escorted us to the exam area but the ultrasound room was occupied. We sat on a bench in the hall outside of the exam room. We sat there waiting for several minutes waiting in silence. Then they asked if we wanted to move into an exam room to wait. I said no, I wanted to get into the ultrasound room right away. They moved us anyway. We sat in the exam room again for several minutes. I could hear people chatting and laughing and see people casually walking by, as the door was open. I began to panic as I didn't understand why we hadn't heard my baby's heartbeat or why the midwives weren't doing anything about it. I asked why they weren't rushing to get me into the ultrasound room. I said "Why isn't it all hands on deck here when you can't find a heartbeat?!" I also said "If you can't get me in for an ultrasound we're leaving and going to the hospital" and grabbed my purse and started to walk out. Rachel said "Please [redacted], let us take care of you" and urged me to wait. At this point I was in the hall outside of the ultrasound room. It then opened and they brought us in. The technician, who had performed by other ultrasounds, hurriedly put the gel on my stomach and then the sensor. The screen was black and we didn't hear anything. Someone said that there was no heartbeat. I was confused, but none of the AABC staff said anything. My mom then took my hands and with tears in her eyes said "Honey we've had a tragedy and lost the baby." I said "No no no no no no" and started crying. They moved us into another exam room and said that we would need to go to the hospital. They asked me what doctor I wanted to be transferred to. I said I didn't know and that they previously said they would transfer me to the doctor that they regularly work with if a transfer was necessary. Rachel said that he was in China and that they would call over to the hospital to find out who could take me and that they were waiting for the on call midwife to arrive to escort us over there. They moved us back into a birthing room to wait. Then Merlene, the on call midwife arrived. We followed her and the ultrasound technician to the hospital. They checked me in and Dr. Morgan came in. They must have taken my blood pressure because he was very concerned about my blood pressure. He said that they needed to confirm that there was no heartbeat even though we had already done an ultrasound at the birthing center. They did an ultrasound and confirmed that my daughter had no heartbeat and was deceased. The technician also indicated that I had almost no amniotic fluid. Dr. Morgan explained that I would have to deliver her and that I would have to choose between a c section or vaginal delivery. He strongly recommended a vaginal

delivery and I agreed. The induction began that evening and I delivered my daughter the next afternoon, May 13 2017 at 3:06pm.

The obstetrician who was there for my daughter's stillbirth, Dr. Brian Monks, came to speak with me and my family afterward. He said that I had almost no amniotic fluid and that the cord was wrapped tightly around her neck. He said that when there is enough amniotic fluid, ,the baby can slide around the cord but since I had almost no fluid, she couldn't do that and the cord had surely been compressed and caused her demise. He asked if my fluid had been monitored recently and I explained that they were concerned that it was low at week 38 but that they determined it was normal and hadn't checked it again in the last 3 weeks. He said that since I was nearly 41 years old and had IVF that I should have been considered a high risk patient and that I shouldn't have been allowed to go past my due date, particularly since my dating was perfect (due to the IVF procedure). He also explained that due to my advanced maternal age, my placenta is more at risk of giving out once I'm past term. He said that he personally would have induced me at 37 weeks but that not all obstetricians would induce me that early, that some would wait until 38 or 39 weeks but that based on my age and the fact that I had done IVF so my dating was accurate, I shouldn't have continued to carry past 39 weeks because my circulation isn't that of a normal, younger mother and the placenta is not likely to continue supporting a baby past term. He said that they never should have accepted me as a patient because mine was a high-risk pregnancy. He said that they also should have followed up on my amniotic fluid level.

I did not know that I was a high risk patient due to my age. I also did not know that it was risky to carry past my due date. AABC was aware of my age and aware that I had undergone IVF (and therefore that my due date was accurate), but at no time did they suggest that I was a high risk patient. I also did not realize at the time that my daughter was falling off the growth scale at the end of my pregnancy. While 15th percentile may be within the "normal" range for size, my daughter went from 50th percentile at my 21 week ultrasound to 15th percentile at 38 weeks. **This should have been a red flag and caused them to recommend closer monitoring as well as obstetric care, per the Informed Choice and Disclosure Statement (see attachment 1, item A3).** In addition, they neglected to transfer me to a medical doctor even after my labor had persisted for five days. When I insisted on an appointment after 3 days of labor, they did nothing to investigate possible complications due to my extended early labor, denied my suggestion for a non-stress test (even though I was past my due date), nor did they follow up on her size or my amniotic fluid level.

I expected from what they presented in their contract with me and verbally throughout my pregnancy, that they would act on ANY red flags that presented during my pregnancy and labor. I also believed that I was a low-risk patient based on their contract with me. Furthermore, I believed based on what their contract said, that they would consult with an obstetrician regarding my pregnancy. Later, after the death of my baby, I reviewed the contract which explicitly states that a patient in early labor for more than 24 hours requires transfer of care (see attached Austin Birthing Center Risk Assessment Tool, page 47 item 11 on Failure to progress in labor). If they had taken that action per their contract, my baby surely would not have died as I would have received the medical intervention that was needed.

AABC RISK ASSESSMENT TOOL

The following list of pregnancy conditions requires special approval by the midwife. Conditions that develop in pregnancy, labor, or postpartum are indications for consultation, case review, and may require additional surveillance to determine low risk status.

Conditions in **bold** indicate ineligibility for registration at AABC or immediate referral or transfer of care if condition develops in pregnancy, labor, or postpartum.

Please review and discuss with a midwife if you believe any of the following apply to your medical history or pregnancy.

Medical History

1. One or more previous premature labors or history of low birth weight infants (<2500 grams). [delivery at less than 37 weeks or less than 5.5 lbs birth weight].
2. Previous shoulder dystocia. [Difficulty delivering shoulders following birth of head]
3. Previous unexplained stillbirth or neonatal loss. [Infant death before birth or within first month of life]
4. **History of incompetent cervix.** [A cervix which opens without labor contractions from weight of advancing pregnancy].
5. Previously diagnosed abnormalities of the genital tract or bony pelvis. [Malformation or obstruction of the vagina, uterus, or pelvis].
6. Previous severe emotional problems associated with pregnancy [e.g., postpartum depression].
7. Previous cesarean section. **Not eligible for care at AABC if more than one cesarean or if prior cesarean was not low transverse.** Will need to provide operative report to show indication for cesarean and type of incision.
8. Previous placental abruption, postpartum hemorrhage, or retained placenta. [Problems at the placental implantation site which result in abnormal bleeding.]
9. Obesity (>30 BMI for first time mom or VBAC client, > 35 BMI for a woman with a previous vaginal delivery) [body mass index (proportion of height/weight)]
10. **Thrombophilia/Clotting disorders resulting in increased risk of blood clotting.**
11. **Epilepsy or other seizure disorder.**
12. Significant mental illness **requiring medication(s) that are contraindicated (unsafe) for pregnancy.** (e.g., schizophrenia)
13. **Mental impairment that would interfere with the ability to follow instructions.**
14. Any other chronic medical problem unless well controlled and determined by midwives and co-managing physician not to pose additional risk during pregnancy or out-of-hospital birth. Must remain under care of physician who will co-manage condition during pregnancy.

15. Pregnancies complicated by other confirmed medical disease (e.g. gestational diabetes, pre-eclampsia, diabetes mellitus, hypertension)

Early Pregnancy

1. Current eating disorder or lack of adequate nutrition.
2. New onset psychiatric disorder or exacerbation of previously diagnosed psychiatric disorder.
3. Positive urine drug screen.
4. **Smoking >1/2 pack per day after 19 completed weeks.**
5. Exposure to known teratogens (e.g. radiation, infection, chemicals).
6. **Cancer requiring treatment in pregnancy.**
7. Grand multiparity with other risk factors. [5 births or more after 20 wks]
8. Abnormal cervico-vaginal cytology [lab result indicating abnormal cervical cells]
9. **Confirmed HIV, syphilis, or Hepatitis B or C diagnosis.**
10. Positive antibody screen. (in cases of Rh sensitization, mother produces antibodies which destroy positive blood type)
11. **Anemia (<9.0 hemoglobin) not responding to treatment.**
12. **Congenital anomaly requiring immediate physician intervention after birth**. [birth defect]
13. **Multiple gestation** [twins, triplets]
14. Incompetent cervix [stitch placed in cervix to keep closed]
15. Late registration for prenatal care, **20 weeks or more without prenatal care.**

Late Pregnancy

1. Late registration for prenatal care:
    a. 28 weeks or more, copy of prenatal records at tour.
    b. **If greater than 32 weeks transferring into care, the following criteria must be met:**
        i. Known last menstrual period or ultrasound dating consistent with uterine growth.
        ii. **Greater than 34 weeks not eligible for registration unless approved by Clinical Director.**
2. Uterine bleeding.
3. **Medication dependent gestational diabetes** [diabetes which occurs during pregnancy]
4. **Preeclampsia or Confirmed Hypertensive Disorder** [high blood pressure with liver or renal dysfunction related to being pregnant]
5. Polyhydramnios [too much amniotic fluid]
6. **Oligohydramnios** [too little amniotic fluid]
7. **Intrauterine fetal death.** [stillbirth]
8. **Thromboembolic disease**. [blood clotting disorders]
9. **Placenta Previa** [placenta is over the uterine opening (cervix)]

10. **Placental edge is less than 2.7 cm from internal os, diagnosed by ultrasound.** [Edge of placenta is less than 2.7 cm from cervix]
11. **Postdates pregnancy at 42 weeks.**
12. **Psychological or social events making an out-of-hospital birthing inappropriate.** [obstructive post-traumatic stress, anxiety, unresolved domestic violence, volatile family members]
13. **Anemia (<9.0 hgb.) at 37 weeks.** [low iron levels or production/absorption problems with red blood cells]
14. **Tumor or other obstruction of the birth canal.** [a tissue or bony blockage]
15. Current active communicable disease.
16. **Non-compliance with prenatal care and education.**
17. Abnormal weight gain in pregnancy.
18. **Estimated fetal weight <5th percentile.** [Baby is small for its gestational age.]

Intrapartum and Postpartum

1. Premature labor [<37 weeks].
2. **Rupture of membranes for more than 36 hours without active labor.** [bag of water is broken]
3. **Evidence of fetal distress in labor.** [baby not responding well to labor]
4. **Unresolved** polyhydramnios **or oligohydramnios** (documented by ultrasound). [too much or too little amniotic fluid]
5. **Development of pre-eclampsia or any hypertensive disorder** [high blood pressure with liver or renal dysfunction related to being pregnant]
6. **Prolapsed cord.** [umbilical cord is below the baby in the birth canal and subject to excessive compression]
7. **Intrapartum or uncontrolled postpartum hemorrhage.** [Too much blood loss during labor or after birth]
8. **Evidence of infection or symptoms of infection.**
9. **Non-cephalic presentation, transverse lie, or breech.** [baby is sideways in the uterus; feet or bottom are in or above the pelvis; or head is not the presenting part at the beginning of labor]
10. **Development of other severe medical or surgical problems.**
11. **Failure to progress in labor:**
    a. First Stage: lack of progress in active labor; or a latent phase of labor over 24 hours in a first labor or 18 hours in subsequent labors. (latent = early)
    b. Second Stage: more than two hours of effective pushing without measurable progress in descent. [from 10 cm dilation until time of birth]
    c. **Third Stage: more than 45 minutes.** [time from birth to delivery of placenta]
12. Any condition requiring more than 12 hours postpartum observation.
13. **Client desires transfer from birth center to the hospital.**

High-Risk Factors Requiring Neonatal Transfer

1. **Apgar score <7 at 5 minutes.** [Assessment scale which assigns values to heart rate, breathing, color, muscle tone, & reflex as soon as the baby is out of the uterus]
2. **Persistent signs of respiratory distress.** [baby having difficulty breathing]
3. **Immediate jaundice, anemia or polycythemia.** [jaundice = yellowing of the skin; polycythemia=excessive red blood cells]
4. **Persistent unstable temperature** [<97 or >100 F. ax after 2 hour of age].
5. **Persistent hypotonia.** [poor muscle tone]
6. **Seizure-like activity.** [convulsions]
7. **Congenital anomaly requiring immediate physician intervention.** [birth defect]
8. Any condition requiring >12 hours observation.
9. **Signs of infection.**
10. **Persistent low blood sugar, not responding to treatment.**

I have read the Risk Assessment, and understand that these conditions may require special approval from the midwives, or may require transfer from AABC care.

[redacted]

Client Signature Date 11-7-2016

Witness Signature Date 11/7/16

TEXAS Department of State Health Services

INFORMED CHOICE AND DISCLOSURE STATEMENT

According to Texas Law, Texas Occupations Code Ch. 203, the Midwife is required to disclose in oral and written form to a prospective client the limitations of the skills and practices of the midwife. The Informed Choice and Disclosure Statement meets these legal requirements. Each midwife may also expand the document into a more extensive information choice agreement reflecting details of her/his practice.

A. In accordance with the Texas Midwifery Act, the midwife:

1. Assists only with normal childbirth except in an emergency situation that poses an immediate threat to the life of the mother or newborn.

2. Encourages each client to seek prenatal, postpartum, and newborn care if not offered as part of the midwife's service.

3. Advises each client to seek medical care if the client develops signs or symptoms of a complication related to pregnancy.

4. Does not use forceps or surgical instruments for any procedure other than cutting the umbilical cord or providing emergency first aid during delivery.

5. Does not remove the placenta by invasive techniques.

6. Does not advance or retard labor or delivery by using medicines or mechanical devices.

7. Does not administer a prescription drug except under the supervision of a physician licensed by the State of Texas, with the exception of oxygen and state approved prophylaxis to prevent blindness of the infant.

8. Does not knowingly or intentionally falsify or make false statements on a birth certificate application. (This offense is prosecutable as a felony of the third degree).

9. Does not use professional titles other than licensed midwife or Certified Professional Midwife (CPM) if certified by NARM.

10. Has explained to the client all the other legal requirements which are applicable to the midwife's practice;

- The newborn screening law requires every newborn to receive testing for certain diseases. A midwife is trained to do compulsory newborn screening, or has made arrangements for it to be done by an appropriate health care facility or physician.
- A newborn baby must receive eye prophylaxis within two hours of birth to prevent possible blindness from infection.
- A serology blood test for syphilis & hepatitis B is necessary during pregnancy and on admission for birth.
- A serology blood test for HIV is necessary at the first prenatal visit and on admission for birth, unless the mother objects. The result of the test is confidential, not anonymous.
- Communicable diseases must be reported.
- Registration is necessary for both births and deaths.
- Compliance with provisions of the Dangerous Drug Act and the Controlled Substances Act is necessary, and other laws as applicable.

11. Has made this form available to the client in English and Spanish.

- Registration is necessary for both births and deaths.
- Compliance with provisions of the Dangerous Drug Act and the Controlled Substances Act is necessary, and other laws as applicable.

11. Has made this form available to the client in English and Spanish.

12. Has made the statistics specified by the Texas Midwifery Board available to each client (see below, under D. Midwifery Experience).

B. Should the client have a complaint about the care she receives from the midwife, she may contact the DSHS Midwifery Program, orally or in writing:

Texas Department of State Health Services
Midwifery Program MC-1982
Professional Licensing and Certification Unit
P.O. Box 149347
Austin, Texas 78714-9347
(512) 834-4523 or 1-800-942-5540

A copy of the complaint form is available on the Texas Midwifery Board's website at:

http://www.dshs.state.tx.us/midwife/

C. The Midwife must also supply the client with the following information:

1. The expiration date of the midwife's license is 2/2017.
2. The expiration date of the midwife's adult and infant Cardiopulmonary Resuscitation Certification (CPR) is 1/2018 and Neonatal Resuscitation (parts 1-4) is 1/2017. Current certificates are required as part of the license renewal process for all midwives.
3. My medical backup arrangements are: Seton Main or St. David's Main for C-Section/non-emergent transports. Closest hospitals for emergencies
4. I am in compliance with all education requirements approved by the Texas Midwifery Board. YES/NO

D. Midwifery Experience

1. I have practiced midwifery for 25 years.
2. Total numbers of birth attended 3000+.
3. Total number of births as a primary care giver 2000+.

All the above requirements and acts in sections A-D have been disclosed to me in oral and written form and I understand them.

[redacted] [redacted] 11-7-2016
Signature of Client | Printed Name | Date

Roswitha Dowell | Roswitha Dowell | 5-23-16
Signature of Midwife | Printed Name | Date

DSHS Publications Number F66-10717
Revised 9/10